# Alberta Advisory Council on Women's Issues

ALBERTA ADVISORY COUNCIL
ON WOMEN'S ISSUES

# MIDWIFERY IN ALBERTA
# A DISCUSSION PAPER

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INDEX


| | Page |
|---|---|
| Council Introduction | 1 |
| Definition of Midwifery | 2 |
| History of Midwives in Canada | 3 |
| Maternal Care in Alberta Today | 7 |
| The Debate | 10 |
| Models for Midwives | 14 |
| Licensing of Midwives | 20 |
| Footnotes | 23 |
| Bibliography | 24 |

## Council Introduction

The Alberta Advisory Council on Women's Issues was officially established by the provincial government in November of 1986, through a Legislative Act. The mandate of the Council is to advise and report to the Alberta Government, and to develop recommendations on any matters relating to women.

The Council has four sub-committees: Economics, Health, Native, Immigrant and Visible Minority Women and a Co-ordinating Committee. The committees study specific issues, examine input related to those issues, conduct research and develop recommendations for Council's consideration and approval. The recommendations are then presented to the provincial government through the Minister Responsible for Women's Issues.

In fulfilling its mandate, the Council invites and receives extensive public input on issues from Alberta groups, organizations and individuals. The purpose of this paper is to solicit such input on the subject of midwifery, as part of the recommendation development process of Council. A questionnaire/fact sheet is available for the purpose of discussion and as a basis for any written submissions which individuals, groups or organizations may wish to forward to Council.

## The Alberta Advisory Council and Midwifery

Concerns about the quality of health care for the women of this province, in meetings and through letters, phone calls, briefs and submissions, are being brought to the attention of the Council. The subject of midwifery was presented to Council at a recent public meeting in Calgary. The Health Committee decided to pursue specific concerns of maternal health care in Alberta by preparing a discussion paper to solicit opinions from Albertans about midwifery.

## Definition of Midwifery

For purposes of this discussion paper, midwifery is defined through the description provided by the World Health Organization (WHO). This definition is endorsed by the International Federation of Obstetrics and Gynaecology and the International Confederation of Midwives. It is also used by most midwife organizations in Canada:

> "A Midwife is a person who, having been regularly admitted to a midwifery education program fully recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery, and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. Her sphere of practice: she must be able to give necessary supervision, care and advice to women during pregnancy, labour, and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, the execution of emergency measures in the absence of medical help.
>
> She has an important task in counselling and education - not only for patients, but also within the family and community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning, and child care."

For purposes of this discussion paper, the additional features as used by World Health Organization to describe the major features of a midwife are presented:

1. To be the recognized expert on NORMAL birth.

2. To have focus on preventive measures and education during the prenatal period, on good eating habits, regular exercise, and the avoidance of alcohol and cigarettes.

3. To have focus on the family, offering information and support to members of the family such as husbands, children, grandparents who are not normally a part of the birthing process in Canada.

4. To have focus on the natural process of birth, seeking to de-emphasize interventions such as drugs, use of forceps and caesareans during the course of a normal low-risk birth.

5. To have focus on the mother and child as a whole, providing emotional, social and spiritual support.

6. To have focus on the individual circumstances of the mother, providing care from conception, through the pregnancy, labour, birth and after birth.

Although midwives have been attending to births for thousands of years, "There is a surprising lack of knowledge about the role and practice of the midwife."[1] Many may be unfamiliar with the above description by the World Health Organization of today's practising midwife. In fact, the midwife may still be perceived by some as the lonely matronly woman attending to a birth in a wooded cabin setting. Such myths and misconceptions exist even today and must be overcome if the practice of midwifery is to be examined in the fullest and most objective manner. This paper will provide a general historical background as well as material on the philosophy and practice of modern day midwives, their role as perceived by various organizations and issues involved in their integration into the maternal care system.

## History of Midwives in Canada[2]

The midwife was once the traditional birth attendant reflecting the elements of traditional holistic care. Historically, the community midwife was considered to be the expert on childbirth. Her training consisted of a long apprenticeship with the practising community midwife prior to that midwife's retirement. The focus of care was on the woman and her family, from early in the pregnancy until long after the child was born. Often the midwife assisted in many additional areas during the pregnancy, from fulfilling household duties to providing emotional support.

Until 1850, midwives practised in all parts of Canada. Where there were a greater number of doctors -- in larger populated centres like Toronto and Montreal -- the competition for a pregnant woman's business increased to the point where doctors began to view pregnancy as an area for specialized medical practice.

Physicians at this time were trying to establish themselves as caretakers of family health. The settlements in Canada were so widespread that many doctors had difficulty finding much business. "It was a small wonder that doctors felt irritable about midwives. At a time when many families relied almost entirely upon their own resources in dealing with illness, birth offered a way for the doctor to gain access to the family, to make an income, and also to begin to build a relationship, to show his skills. He found himself in competition with women who relied on farming for their income and helped out at births on the side, and who therefore had no need to charge high fees or even to charge at all. The doctors therefore had a serious leak in their system. The law

was not working as a deterrent. In the 1860s to 1880s, doctors began to organize and decided that birthing was a medical procedure."3

"The efficacy of the eighteenth century brand of care was seen in the practice of midwifery, which was the only form of medicine women participated in.... Midwives had to serve lengthy apprenticeships before being certified and, for the most part, learned how to let nature take its course. Midwives seem to have taken good care of their female patients and most certainly did less harm than male doctors in the 1800s, many of whom routinely infected their patients with "puerperal sepsis" (childbed fever) by failing to wash their hands."4

With the rise of medical schools in Canada and the subsequent graduates, doctors began to immigrate west to obtain positions not available in cities already oversaturated by the medical profession.

In 1865, the federal government assigned midwifery to be placed under the jurisdiction of the licensed medical practitioners. Midwives were to be under the control of physicians though their independent practice continued for some time after the implementation of the new legislation. This continuation of practice could be for a variety of reasons including the lack of physicians in many outlying areas to a long standing trust in the community midwife. The use of the midwife was gradually eroded starting first in the larger cities where there were more doctors, then the rural centers and finally the outlying and northern communities.

"Modern obstetrics seems to have made very little accommodation with the popular birth culture. The guiding principle of obstetrics, as we shall see, was the clean sweep. In order to justify this sweeping motion, it was necessary to promote the view that traditional childbirth was dirty and potentially dangerous."5

During the late 1800s, the physician oversaw the birth but the majority of births were still in the home. Hospitals were overcrowded and dirty which led to the spread of infections. It was the poor women who gave birth in a hospital.

In the 1890s, Ontario and Quebec improved the state of their hospitals. At the same time, there was an expansion of medical colleges offering degrees to men to practice medicine in Canada. As a result, the pressure was from the doctors to move these women into hospitals to give birth. The increased number of doctors and the increased pressure for women to have children in hospitals changed the practice of maternal care.

With the rise of mechanization in all aspects of the modern world, anything progressive was considered to be better and more sophisticated. City women, unlike rural women, were able to read magazines portraying what a sophisticated woman does at birthing time. "Techniques of modern birth already available at this time included induction anaesthesia, and mechanical or surgical tools for separating the foetus from the mother."6 Midwives did not use this type of sophisticated equipment. Thus, the social trend was to consider midwives less able to help with birth.

By 1950, the midwife, except for the extreme northern communities, had no recognized place in the maternal care system in Canada.

At this time, in accordance with recognized medical procedures, men were not allowed in the labour room; drugs, forceps and surgery were used commonly. In the 1960's, social changes such as the women's movement, consumer movements and increased awareness of personal responsibility affected the maternal care system. Women began to think of themselves as consumers of maternity services beginning a resurgence of the practice of midwifery. The Midwife Association of British Columbia states that with the beginning of alternate lifestyle settlements in their province, midwives were becoming predominant for that culture.

## Maternal Care in Alberta Today

In Alberta today, most specialized maternal health care is provided by the 120 obstetricians in the province. Only those physicians who are registered with the College of Physicians and Surgeons can practise medicine in the province of Alberta. The College issues licences to practise and in the Alberta Medical Profession Act, it is an offence to practise medicine without a license. The legislation states that "An unlicensed midwife may, however, practise in a territory that is not within the limits of a town or village which has a resident registered practitioner in midwifery."

The Alberta Hospitals and Medical Insurance Act insures all services rendered by a physician. The services of an unregistered midwife would not be covered under the existing act. According to the College of Obstetricians and Gynaecologists, a government which is having difficulty funding current health care programs would have difficulty funding midwifery programs.

According to the Canadian Medical Association, large insurance costs and the advancing technology of obstetrics have caused many general practitioners to opt out of maternal health care and refer patients to an obstetrician. Thus the continuity of care is broken. According to the College of Obstetricians and Gynaecologists, obstetricians in Alberta pay $9,800 in insurance costs per year and question how midwives will be able to afford these premiums. The Alberta Medical Association states that consumers demand a specialist's attention instead of using a general practitioner. Obstetricians often work long and odd hours, and according to the Alberta Medical Association, general practitioners are also opting out of maternal care for lifestyle reasons. In Alberta, hospitals which offer tertiary care restrict admitting privileges to specialists. Thus the general practitioner will not have access to a hospital to admit their pregnant patients.

A pregnant woman's entry into the maternal care system in Alberta would most likely consist of a first visit to her family doctor. After initial diagnosis, this family doctor would most likely refer the woman to an obstetrician. According to the Alberta Medical Association, the obstetrician is paid a lump sum for prenatal and postnatal care and for delivery. If this is a low-risk, no complications pregnancy, the physician is paid $445.

The prenatal care consists of monthly visits until 28 weeks; biweekly visits until 36 weeks; and then weekly visits until term. The postnatal care consists of one visit after six weeks, sometimes a visit after three weeks.

According to the Alberta Medical Association, in the large centers, such as Edmonton or Calgary, some pregnant woman have two physicians -- one who supplies the pre-natal care and one who does the delivery. If this happens, the fee is $238 for the pre- and postnatal care and $297 for the delivery. This lack of continuity of care is mainly because of obstetrical privileges lacking from one physician or the inability of one physician to arrive in time to deliver the child.

With the increasing costs in insurance and office expenses, and the inability of the health care system to keep up with the rising costs of the maternal care system, obstetricians make less and less money assisting in the normal birth of babies.

According to the Alberta Association of Midwives, many women are feeling out of touch with their obstetricians. In first pregnancies, most likely the woman has had no previous contact with the obstetrician and is often referred to other programs for additional (excluding medical) prenatal and postpartum care.

The Manitoba Advisory Council on the Status of Women, supporters of midwifery services for their province, state that new mothers and their babies are quickly turned out from the hospital to manage with little or no support from the medical community. "Maternity care in Canada tends to focus on labour and the delivery of babies and not on the prenatal and postpartum phases. During the prenatal period, most physicians are unable to provide adequate hours for preventive care. With the exception of a pre-scheduled physical checkup

approximately six weeks after childbirth, most new mothers and their babies are quickly turned out into the community with little or no formal supports."

The Alberta Medical Association maintains that pre- and postnatal care in Alberta is very good and more than sufficient to meet the needs of the pregnant woman.

The Canadian Medical Association states that there are conflicting public attitudes. With the new technology, pressure mounts for perfection at birth. "Modern obstetrics has created such a level of expectation that some couples expect nothing less than a perfect birthing experience, especially when pregnancy has been delayed to the mid-thirties and/or when the couple plans to have a single child."

The Debate

Arguments against the current maternal care system in Alberta seem to center around 1) quality of care; 2) continuity of care; 3) the traditional values of the midwifery care; and 4) consumer rights.

While doctors claim that Canada has a successful, highly satisfactory and readily accessible obstetrical care system, midwifery advocates state that midwives can fill a place in the maternal health care system by giving the best continuity of care. The Alberta Association of Midwives state that "The principle of continuity of care cannot be stressed enough. Families need the care of a known and trusted team of caregivers, and the system must allow for this. To be truly effective this care should start before conception or in early pregnancy, and should continue until the early postnatal

weeks. Families may come in contact with many different professionals throughout this time, resulting in difficult communication and a lack of trust because no one individual sees them throughout the process. At present, families in Canada are left with virtually no postnatal care from the time of their (increasingly early) discharge from hospital. This contributes to a range of problems including early discontinuation of breastfeeding and postnatal depression."

Although the midwifery advocacy groups have had a vocal voice to the contrary, the Canadian Medical Association (CMA), from data collected from its independent survey, states that "Ninety percent to 95 percent of Canadian women are at least somewhat satisfied with their obstetrical care." The CMA concluded that "The overwhelming majority of Canadian women who have given birth are very satisfied with the quality of obstetrical services they received."

The Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth state that "The doctor's time is seen as valuable and a childbearing couple often does not have the opportunity to develop a trusting relationship." The Association further states that "Physician's training has an emphasis on intervention, especially in dealing with the unusual. Normal, uncomplicated births must be recognized as the norm.... Midwifery offers continuity of care by providing services through the childbearing cycle. The services incorporate prenatal classes, care during pregnancy, labor and delivery, and post natal care."

Sandra Botting, a midwifery advocate, in her paper, Midwifery, states that "There are major psychological repercussions from being hospitalized and treated as a patient in childbearing.

Hospitals are hierarchical institutions, set up for economical efficiency, and as teaching institutions for nursing and medical students. In donning a hospital gown, the person loses individuality, and to a certain extent control. Relationships are inhibited, relaxation and confidence (so important for labouring women) are difficult to achieve in the busy hospital environment. Studies have shown the effect of fear and tension on animals and humans. Hormonal changes occur that actually inhibit and some times stop the cervix from dilating. Infection rates are higher under stress. The woman's self-confidence in her body and mothering skills are very much affected by her experiences in childbirth. The emotional and psychological aspects of childbirth have largely been ignored by modern medicine."

The Alberta Medical Association refutes these claims by midwifery advocates by stressing that "They would like to see this type of information substantiated by empirical research."

According to the Manitoba Advisory Council on the Status of Women, "The view of childbirth as pathology has led to an increase in the development and use of sophisticated technology in obstetrics... the use of technology is essential in a small number of cases, such interventions have increasingly been employed by physicians as preventive measures in cases of low-risk pregnancy and childbirth."

Many advocate groups feel that maternal care is an issue of consumer rights. Katie Hughes, in her paper "Midwifery in Canada", states that "In order to have real reproductive

choice, women need access to midwives. Reproductive choice entails not only a women's decision whether to give birth but also her choice of how to give birth. Birth in North America is rapidly being transformed by the medical profession into a high technology procedure where the women is merely a passive birthing vehicle. Midwives are fighting to bring birth back into the control of women. The present midwifery issue is not simply a call for the return to natural birth but is an issue tied in with issues of reproductive rights, sexual and economic power struggles, patients' rights and radical health consumerism."

Most midwives in Alberta are from countries with systems which recognize their unique place in maternal health care. The Canadian Medical Association states that "The proponents of a system that would license midwives, base their views on the premise that such systems exist and function well in other countries. However, such systems existed long before the era of modern obstetrics and have grown within the current system. In those countries the continued development of the role of midwives was consistent with the traditional expectations of these societies." It has been pointed out by both sides the difficulties faced in recognizing the midwife without recognizing the system from which she came.

According to The Ontario Task Force on Midwifery, "How well she (the midwife) can function in an environment that recognizes her but not the tradition from which she arose is a puzzle."

Sandra Botting also suggests that neither tradition nor the midwife is accepted by the medical community. "A very emotionally charged, political situation exists within physician organizations. Doctors feel threatened both

economically and in position, since they have enjoyed a monopoly on who practises and what kind of practices occur. This monopoly might be justified if better outcomes could be claimed by the physicians groups."

According to the Canadian Medical Association, "The successful outcome of recent day obstetrical care has dimmed the memories of maternal and fetal mortality (vividly remembered by contemporary grandmothers) and created the attitude that since pregnancy and childbirth are natural phenomena, they should not be medicalized to the point that we observe today."

The National Action Committee of the Status of Women, a national feminist organization, states that "The midwifery movement does not seek to replace obstetricians or to exclude general practitioners from participation in birth. It seeks to widen, not to narrow the options available to birthing mothers. It seeks cooperation and consultation with the medical profession. Both obstetricians and midwives will always be needed."

The Alberta Medical Association sees the midwife as an "add-on" to the present maternal care system. The Medical Association states that an obstetrician is the best provider of maternal care and that a midwife can be an assistant, but not an equal partner, of the obstetrician.

According to Katie Hughes in her paper Midwifery, "Canada has the dubious distinction of being the only western industrialized nation which does not make provisions for midwives in our health care system." Sweden, where midwives attend 75 per cent of all normal births, has an 8.6 per cent infant mortality rate. Canada, who ranks fourteenth in the

birth mortality rate as opposed to Sweden's first-ranked position, has a birth mortality rate of 10.9 per cent. Birth mortality rates in this case, tend to support the use of midwives in the maternal care system. Birth mortality rates, however, do not just reflect the maternal care system, but also reflect the economic and social factors of the country.7

Canada is one of the nine member countries in the World Health Organization that does not have an established midwifery system. In other countries, midwifery is a profession separate from both nursing and medicine with separate governing powers and education.8

There is no province in Canada where midwives have legal recognition, but it is estimated that there are 200 practising midwives in Canada. In Ontario, legislation is currently being studied. Most midwives have received their training in another country (Britain, Sweden, etc.) and have immigrated to Canada. Most of these midwives are non-practising, working in hospitals as nurses.9 According to the Alberta Association of Midwives, there are few midwives practising in Alberta today.

Models for Midwives

For the purpose of this discussion paper, the Alberta Advisory Council on Women's Issues presents the following models for midwives:

Direct-Entry Midwife: Defined as an educationally prepared and licensed professional who practises midwifery in a home or hospital setting. In such countries where a midwifery system is established, it is recognized as a formal part of the total health care system.

Lay-Midwife: Defined as an unlicensed individual who has not completed a recognized training program and practises in a home setting.

Nurse-Midwife: Defined as a registered nurse who has received additional midwifery training and practises in a hospital setting.

Most midwife advocates believe that midwives can also be direct-entry midwives, without nursing degrees. The Alberta Association of Midwives states that "Midwives in all other industrialized countries have a rigorous clinical and theoretical training, and are responsible for conducting the deliveries of 70 per cent of the world's children." The Association further states that "None of the (World Health Organization) principles require previous training in medicine or nursing. ...There is certainly evidence that excellence in midwifery practice can be attained without nursing training, especially in the experience of the health care system in the Netherlands."

In the Netherlands, where most births occur at home, midwives are prepared in a rigorous and competitive three-and-a-half-year program. In Sweden, where most births occur in a hospital, all midwives are nurses, followed by midwifery training after which they are licensed under the Midwifery Act. In Great Britain, where most births are overseen by an obstetrician, midwifery has its own educational standards and governing body. 10

Midwife advocates would like to see a separate training program developed for midwives. The Alberta Association of Midwives, in concurrence with midwife associations from across

the country, would like to see a direct-entry program consisting of a four year university degree. Credits would be given for nursing courses or midwifery courses taken in other countries.

A common misconception with the idea of a midwife is that all midwives do is assist in home births. Home births are completed in the home with little or no medical intervention. According to advocates of midwifery, home births for low-risk women are a safe alternative to hospital births. A planned home birth, according to these groups is the most natural place for family-centered maternity care.

The Alberta Association of Midwives states that a properly trained and regulated midwife should be the main presider over birthings. The Association also states that home births, provided that they are low-risk women, can be as safe and more comfortable for the family than hospital births.

The Netherlands, which allow home births in 95 per cent of all maternity cases, rates second in infant mortality rates. "With the attendance of a professional midwife and the proper back up and support of the medical system such as a skilled attendant, properly prepared parents, healthy low-risk pregnancies and available emergency facilities, the outcomes of domiciliary deliveries have been proven to be safe. A system that encourages safe home births would make this a viable option for the families who choose this setting."[11]

The Alberta Association of Registered Nurses stresses that it can not support home births within the current health care delivery system.

Both the Alberta Medical Association and the College of Obstetricians and Gynaecologists do not support home births in any form.

A nurse-midwife is the midwife model most accepted by the medical profession. They are used most frequently by Sweden which has the lowest infant mortality rate. A nurse-midwife would be a trained nurse who has had extra training such as the graduate program at the University of Alberta. The Alberta Association of Registered Nurses "does not support designating the occupation of domiciliary midwife as a health occupation." They believe that "assisting at childbirth belongs within the exclusive scope of practice of the registered nurse."

The Association believes that "complexity of the tasks is such that the education preparation needs to be that of a registered nurse (RN) with at least one year's post-RN midwifery education, with extensive supervised practice in management of pregnancy, labour, delivery, and the postpartum/newborn period. Practice should be limited to hospitals or birthing centers."

The Alberta Association of Midwives argues that "to establish a costly double training system for nurse-midwives requires strong evidence in its favour; that evidence is so far lacking."

The Alberta Association of Registered Nurses (AARN) "supports nurse-midwifery as a valid area of nursing practice." The AARN, in accordance with all other nursing associations in Canada, supports the "independent role, and the collaborative role with physicians, maternal-child nurses, community health

nurses and other health disciplines." The AARN defines the nurse-midwife as a nurse who is registered in Alberta, has completed a recognized education program in nurse-midwifery, and holds the requisite qualifications to practise nurse-midwifery in Alberta. Nurses holding such qualifications are currently employed by hospitals as nurses working in obstetrical wards.

The University of Alberta has set up a graduate program in nurse-midwifery. Dr. Peggy Ann Field, head of this graduate program, sees midwifery as an issue of consumer rights. "If you really believe in consumer rights, you have to look at the whole issue calmly and rationally and see if it's possible to provide the consumer with what she wants."

According to the physician groups, nurse-midwives, should they be introduced into the medical system, would participate in births in hospital settings. According to the Alberta Registered Nurses, the best maternal care system would incorporate nurse-midwives working in hospital settings. The Alberta Chapter of Gynaecologists and Obstetricians states that "Midwives could practise under the supervision of a licensed obstetrician in a hospital setting." Most medical groups support the concept of midwives as long as they are under the supervision of a licensed obstetrician.

In reaction to public pressure, most hospitals which have an obstetrics ward are now introducing birthing rooms. The more relaxed atmosphere of the birthing room allows the woman to go into labour and deliver in the same setting. They also allow for the mother and baby to stay in the same room. Dr. Fawzy Morcos, head of the recent midwifery project at the Misericordia Hospital in Edmonton, states that "With greater

participation of the consumer and her family in family cinctured maternity care, more and new demands are being made on physicians, nurses and hospitals, i.e., the providers of maternity care. These demands include the desire to give birth in a place other than a traditional hospital labour and delivery room, i.e., birthing room or an alternative birth center. Requests to give birth in other than the conventional position, e.g. standing, squatting, kneeling on a birth stool or sitting in a birthing chair, little or no analgesic and appeals for the presence (in addition to the father) of a birth attendant."

A study was recently completed in Alberta to test the feasibility of midwives in the current system. Dr. Fawzy Morcos completed a study at the Misericordia Hospital between 100 low-risk women attended by midwives (who were overseen by physicians) and a control group of equally low-risk women attended by physicians in the conventional manner.

The study involved six registered nurses trained as midwives in Britain and two experienced obstetrician nurses untrained in midwifery.

Dr. Morcos's study found significant differences between the experimental (midwifery) and control groups on:

1. Mean length of stay postpartum - less in the midwifery group;
2. Less stress tests with the midwifery group;
3. Much higher proportion of the control group had sedation during labour;

4. Much higher proportion of the control group had forceps delivery;
5. Much higher proportion of the control group had an episiotomy. But more of the midwifery group had perineal tears;
6. Mean duration of labour (third stage only) is significantly longer for midwifery group than for control.

The purpose of this study, according to Dr. Morcos, "Any findings which might be used as basis for further discussion must confine itself to the basic principle ie. midwives in a hospital setting as part of a team where the obstetricians direct and act as consultants."

British Columbia has done several studies on midwifery. The latest is a pilot project developed by the Ministry of Health to be used in several hospitals in British Columbia. Dr. Paul Pallin, head of the government's project states that with the current public attitudes in British Columbia, midwives are "a long time coming" for their maternal care system. So far, the lack of funds for this project has halted the progress.

Licensing of Midwives

If the midwife is to practise in Alberta, the Midwife Association of Alberta and those across Canada feel that the midwife must be an independent body licensed under the Health Occupations Board. With this autonomy, midwives would function as the experts in normal birth, working with physicians and nurses for the betterment of maternal health care within Alberta.

According to the College of Obstetricians and Gynaecologists, midwives could either be employees of the hospital or employees of the physician. With the government having so many financial difficulties funding health care, the only feasible possibility would be obstetricians hiring midwives and they are not certain that physicians would feel the need.

The Associations of Midwives of British Columbia, Ontario and Quebec have proposed legislation that would give the midwives autonomy and the ability to work in collaboration with the doctors of their respective provinces.

The recent task force on midwifery in Ontario recommends Ontario should train and license midwives as independent professionals. The task force also recommends that a college of midwifery be created to regulate the profession and that an interim training program be initiated to bring practising but unlicensed midwives into the new regulated system. A recent case regarding the prosecution of two Vancouver midwives for a failed home birth has brought recommendations to the British Columbia government for a panel to examine midwifery as it pertains to this case and report to the government no later than September 1, 1988. The British Columbia Midwifery Task Force feels that the system is running out of time to do studies, midwifery must be regulated as soon as possible.

The Alberta Association of Midwives, as do most other midwifery advocates, supports the concept of professional qualifications and a separate governing body. This type of legislation would, the association feels, reduce the number of midwives practising without proper qualifications.

The Midwifery Association in Alberta applied for licensing under the Health Occupations Act in 1983. The Association was turned down. The Alberta Medical Association supported this decision and continue to stress that "midwifery not be recognized as a health occupation by the Health Occupations Board." According to Dr. Cheryl Anderson, a former midwife, in Canadian Family Physician, January 1986 "A recent survey of family physicians practising obstetrics in Alberta, 22.5 per cent approved of midwives for delivery and 7.8 per cent would attend home births themselves if authorized by the College of Physicians and Surgeons of Alberta. She further states that "there is a loose association between the physician and midwife providing parallel care to the pregnant woman who wants a midwife attended birth. The midwife needs to know there is reliable medical backup for her client, and the physician needs to provide reasonable care to the woman regardless of her planned circumstance for delivery."

The Canadian Medical Association states that obstetrical nurses could be further trained to assume more responsibility in obstetrical care. However, given current expectations and the legal need for someone to assume ultimate responsibility, these professionals could not function in a totally autonomous manner.

The nursing associations in Canada see the midwife as being licensed and governed under their respective associations. They would be willing to recognize midwifery as a speciality of nursing but do not believe in the self-governing of midwives.

FOOTNOTES

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4. C. Hymowitz and M. Weissman, A History of Women in America, Toronto, 1981.

5. The Ontario Task Force on the Implementation of Midwifery, 1987 Report.

6. Ibid.

7. World Health Organization, Maternity Care in the World, 1976.

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9. Statement from Canadian Association of Midwives, 1987.

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